That tissue, in its normal condition, transmitted through the bougie the sensation of travelling along a velvety path; and, if there were any constriction, not only would that fact be communicated to the surgeon, but also the degree of pathological change which the urethra had undergone. The *bougie à boule*, therefore, would detect stricture of the urethra in its earliest stage; and the treatment of such stage might correctly be termed the preventive treatment. When a patient went to a surgeon for a gleet, he ought always to be examined with the *bougie à boule*, for it was necessary to ascertain the pathological condition of the canal before an appropriate treatment could be decided on. If there were no constriction, deep injection was proper; but if there were contraction, however slight, it would be aggravated by injection, but cured by gradual dilatation. Mr. Teevan, after enunciating M. Mercier's views of the pathology of stricture, discussed the seats of stricture, as deduced from facts observed by himself. He grouped together stricture at the bulb or membranous urethra, and called it "subpubic." This was by far the most common kind of stricture, simply because the triangular ligament favoured its production. The next stricture in order of frequency was the "penile," situated at a spot varying from two-and-a-half to three-and-a-half inches from the meatus externus. This stricture was rarely absent, in some degree, when the other was present. The rarest form of stricture was that just within the meatus, the "orificial." Strictures, regarded in their physical conformation, were of two kinds—the "tunnel" stricture and the "ring" stricture. He called them so on account of the sensations communicated to the *bougie à boule* when passing through them. Subpubic strictures were generally of the tunnel kind; orificial strictures were of the ring character; and penile strictures partook of both forms. The measurements given of the length of the urethra varied from seven to eight or nine inches. He had found the average length to be seven and one-eighth inches, as deduced by himself, from measuring the urethra of one hundred males. Regarding the treatment of stricture, he stated that, after witnessing the practice of various surgeons, and trying different methods, he had come to the conclusion that there was no treatment equal to that of gradual dilatation by means of the *bouge olivaire* and the piliform bougie, which treatment, he believed, he was the first to introduce into English hospital practice. Forcible dilatation was only applicable to the easier kinds of strictures; it was not devoid of danger; it caused an unknown lesion; it had to be always followed, and often preceded, by gradual dilatation, so that it could only be regarded as an occasional auxiliary in the treatment of stricture. Gradual dilatation was the safest treatment for the patient, for, out of one thousand recorded cases, there had not been one death; all the sufferers could be treated as out-patients, and no man need ever lose an hour's work during the treatment. The *bougie olivaire* glided in so easily that the patient was scarcely aware of its presence. It was necessary to pass an instrument about once in every three or four months, even after an apparent cure. Dilatation ought to be conducted up to the highest size that the urethra would take.—*Brit. Med. Journ.*, Nov. 6, 1869.

55. *Holt's Dilator for Stricture.*—Mr. D. M'GREGOR, late Superintendent of Barnhill Hospital and Asylum, says (*Ed. Med. Journ.*, Oct. 1869): "Although this instrument has been several years in use, I do not think advantage has been taken so extensively as might be of its decided usefulness. Only in four cases have I had occasion to use it, and in all the four with the most perfect success. Indeed the cure was so remarkable that I think (if I may be allowed to judge from so limited a number) in all suitable cases for this instrument it is a needless loss of time, in hospital practice at least, to spend weeks upon the gradual dilatation of stricture when it can be safely done in most cases in fewer days. In my four cases I had a difficulty in passing a No. 2 catheter at first into the bladder, after which Holt's instrument was passed, and the stricture ruptured or forcibly dilated, so as allow a No. 10 gum elastic to pass with ease. In none of the cases did a bad symptom follow, except a slight shivering in one; and, save passing the No. 10 once a day for two days, there was no further interference necessary. The urine was passed in all of them in a large and easy stream, and they were at once dismissed well. I noticed, in his recent excel-

lent lectures on the surgical diseases of the urinary organs (published in the *Lancet*), that Sir Henry Thompson, though he speaks favourably of Holt's dilator, prefers cutting stricture by means of a bladed instrument introduced into the urethra. I consider this, however, a much more difficult and dangerous proceeding than the other, while I scarcely think it more successful."

56. *Dr. Dolbeau's Use of Alcohol in Dressing Surgical Wounds.*—The following is Dr. D.'s (the eminent surgeon of Hôpital Beaujon) plan of proceeding. Having performed the amputation, or removed the tumour, as the case may be, he stanches the hemorrhage, by such means as are appropriate and usual in the circumstances. He then washes the wound with what he calls *pure* alcohol; or, in other words, with the strongest commercial alcohol, unmixed with water. The next proceeding is to dry the bleeding surface with fine soft linen. The dressing is now applied. This consists in filling up the cavity caused by the loss of substance, or covering the flaps of the amputation with feathery tufts of fine charpie soaked in pure alcohol. The part is then farther covered with compresses, which likewise are soaked in pure alcohol. The dressings are then inclosed in a double envelope of the impermeable gutta percha tissue, which has of late years superseded oiled silk for most medical and surgical purposes, and which is superior in respect of elasticity and cheapness. The whole of the dressings and coverings now described are retained in position by a few rounds of a bandage.

The dressings now described—applied, be it observed, when all bleeding has ceased—remain undisturbed till the following day, when they are entirely renewed. During the course of the day, it is useful to open up the impermeable covering, and, without touching the underneath dressing, moisten it with pure alcohol. At each dressing, it will be found that the charpie is adherent to the raw surface: to detach it without causing an oozing of blood, the dressings ought to be moistened by means of syringing it with alcohol.

When the proceedings as above described are carried out with exactitude, there is no bleeding from the wound, and the parts are kept in a favourable state of moisture. At the end of a period, varying from five to ten days, the raw surface is quite dry, and presents a slate-gray appearance. The surface may be kept in this dried-up state—in this condition of local embalmment—as long as is desired. Cicatrization proceeds very, very slowly; and to accomplish permanent healing, it is necessary to induce suppuration in the wound.

Dr. Dolbeau holds that his method of alcoholic dressing prevents the occurrence of traumatic inflammation; and I am assured by friends who have had considerable opportunities of observing his hospital practice, that this opinion is well founded. He says—and this I have personally observed—that the patients have generally little or no fever, and that their strength is inversely proportionate to the suffering they have had or the quantity of blood they have lost in the operation. By keeping the wounds in the state of alcoholic dryness (*sécheresse alcoolique*), as Dr. Dolbeau calls it, traumatic reaction is prevented; and by that means, any necessary length of time is obtained for the patient to get up his strength.

When all goes well—when the appetite and sleep are natural—when strength is regained, the alcoholic treatment is discontinued, and glycerine is used. The time has now come, according to Dr. Dolbeau, when, without detriment, the patient can support suppuration. The surgeon, however, after instituting suppuration by dressing with glycerine, may, if he think it necessary, arrest or diminish the formation of pus by using pure alcohol, or a mixture of alcohol and water.

At first, the alcoholic treatment occasions a good deal of pain; but, by the end of the second or third day, the wound has become insensible. Some patients beg urgently that the alcohol may be used somewhat diluted with water, but Dr. Dolbeau says that this demand ought to be resisted.

The direct application of pure alcohol often vesicates the skin surrounding the wound. When this inconvenience occurs, it is easily remedied by powdering the blistered surface with starch or rice. In a few exceptional cases, the lips of the wound become greatly swollen, while the surface of the wound has